Diabetes Medical Management Plan **Cape May County Technical School**

This plan should be completed by the parent/guardian and reviewed by your child's Diabetes Management Physician or Nurse practitioner.

Parent/Guardian: If you do not supply the annually updated medical plan, your child will not be permitted to participate in sports or any off campus activity, including field trips.

Student's Name
(Print): ________________________________ Date of Birth: ____/____/____ Grade: _____ Full or Half Day

Circle one: Diabetes type 1 Diabetes type 2 Year student was diagnosed: ___________

Other conditions you would like school personnel to know of: ___________________________________

Contact Information

Parent/Guardian: ____

Address: ____

Telephone: Home __________________ Work _________________ Cell_________________

Other Emergency Contacts:

Name: ____ Relationship: ___________________

Telephone: Home _________________ Work _________________ Cell __________________

Student's Primary Doctor/Health Care Provider: Name: ____

Office Location City/State: _______________________ Telephone: _______________

Student's Diabetes Physician or Diabetes Team: Name: ____________________________

Office Location City/State: _______________________ Telephone:___________________

HYPOGLYCEMIA (Low Blood Sugar): What are your child's typical signs or behaviors?

____

HYPERGLYCEMIA (High Blood Sugar): What are your child's typical signs or behaviors?

____

Blood Glucose Monitoring: Is your child able to perform own blood glucose testing? Yes No

Type of blood glucose meter used: _____________________

Times to do blood glucose checks (*check all that apply*):

☐ Pre-meal times (circle): breakfast lunch dinner ☐ Prior to bedtime ☐ Before exercise ☐ After exercise

☐ Hyperglycemia symptoms ☐ Hypoglycemia symptoms ☐ Prior to driving or operating hazardous machinery

☐ Other (explain): ______________________

For Students Taking Oral Diabetes Medications:

Name of medication: _______________________ Dose: ________ Times taken: __________________

Are modifications to your child's educational program needed? ☐ NO ☐ YES

If "YES", parent/guardian please contact the school's 504 Plan Coordinator or Guidance Counselor.

For Students on Insulin Pump: Pump Type: ______________________ Type of insulin: _________________

Basal rates: _____ 12 am to _____ Basal rates _____ _____ to _____ Basal rates _____ _____ to _____

Type of infusion set: ____

Student Pump Abilities/Skills: Student is knowledgeable to:

Count carbohydrates? Yes No

Bolus amount for carbohydrates consumed? Yes No

Calculate and administer corrective bolus? Yes No

Troubleshoot alarms and malfunctions? Yes No

Calculate and set basal profiles? Yes No

Calculate and set temporary basal rate? Yes No

Disconnect pump? Yes No

Reconnect pump at infusion set? Yes No

Prepare reservoir and tubing? Yes No

Insert infusion set? Yes No

INSULIN PRESCRIBED VIA INSULIN PEN OR SYRINGE:

MORNING Insulin(s): **Type:**_____________________________**Dose:** ____________

Type:_____________________________**Dose:** ____________

LUNCHTIME Insulin(s): **Type:**____________________________ **Dose:** ____________

Type:_____________________________**Dose:** ____________

DINNERTIME Insulin(s): **Type:**_____________________________**Dose:** ___________

Type:_____________________________**Dose:** ____________

EVENING/NIGHT TIME Insulin: Type:_____________________________**Dose:** ____________

Meals and Snacks Eaten at School:

Is student independent in carbohydrate calculations and management? Yes No

Daily Meal/Snack Food number of carbohydrates prescribed:

Breakfast carbohydrate:_____gm *Mid-morning snack carbohydrate: _____gm*

Lunch carbohydrate:_____gm *Mid-afternoon snack carbohydrate:_____gm*

Dinner carbohydrate:______ gm *Bedtime snack carbohydrate: _____gm*

Snack before exercise? Yes No Snack after exercise? Yes No Estimate snack carbohydrates: ____gm

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):
____

The following supplies are to be provided by parent/guardian:

_______Blood glucose meter, blood glucose test strips, batteries for meter
_______Lancet device, lancets, gloves, container for sharps disposal, etc.
_______Urine ketone strips
_______Insulin pump and supplies
_______Insulin pen, pen needles, insulin cartridges
_______Fast-acting source of glucose such as glutose tablets or glutose gel
_______Carbohydrate containing snack(s) (Provide meal if staying after school.)
_______Glucagon emergency kit for school nurse/delegate. (If child is in sport need one for team kit also.)

Note: If your child is sick and following "diabetic sick day rules" he/she should remain home until well.

Parent/guardian signature: ______________________________ Date: ____/____/____

******************** Physician/Nurse Practitioner to complete ******************

Work and/or Sports Considerations:

Is student restricted from heights or activities that may involve the safety of other students (ie. examples: part of a pyramid and throwing/catching stunts in cheerleading, spotting weight lifter, climbing ladders, working with hazardous machinery, welding, etc)? ☐ NO ☐ YES: If "YES", what safety considerations are there?

____

Needs to test FSBS test prior to sports/exercise/work/driving? ☐ NO ☐ YES Repeat FSBS every ____ hours.

Student should NOT exercise if blood glucose level is below ____ mg/dl or above ____ mg/dl **OR** if moderate to large urine ketones are present.

YOU MAY SUBSTITUTE A COPY OF DIABETES MANAGEMENT PLAN FOR THE FOLLOWING INFORMATION: *(must be signed by health professional)*

Target range for blood glucose is: **70-150 or 70-180 or Other**: _____ - ______

Insulin Correction Doses

Correction formula if blood sugar is above _____mg/dl before meal. Circle one: Humalog or Novolog or Apidra

Calculation of insulin units needed to reach target blood sugar:

Premeal FSBS reading equal to or above: (_______). *Subtract* _______ (target blood glucose).

Then *divide* by ______ Equals # of units needed. Each unit of insulin reduces blood glucose by ____mg/dl.

Insulin to carbohydrate ratio? No Yes If, "YES":

Insulin:__________________give ____ units for every _____gm of carbohydrates eaten via: pump syringe

HYPERGLYCEMIA:

Call parent/guardian if FSBS _____ or above. If pre-meal result follow **Insulin Correction Dose** formula orders.

Urine should be checked for ketones when blood glucose levels is above ______ mg/dl. or if vomiting.

Ketones (moderate-large) administer (in addition to sliding scale insulin correction dose formula orders):

Insulin:_______________ dose: ____U and water or Crystal lite ____ oz per hour.

HYPOGLYCEMIA:

If FSBS below ____mg/dl give: ____ gm of CHO. Send to lunch if lunchtime unless symptomatic.
If symptomatic wait 15 minutes and re-test. FSBS is below ____ mg/dl give another ____ gm of CHO.

SEVERE HYPOGLYCEMIA:

Student is unable to swallow, or is unconscious, or having a seizure Glucagon is to be given (parent/guardian is to provide supply of Glucagon to school nurse and coach).

Route _______, Dosage _______, site for glucagon injection: _______arm, _______thigh, _______other.

If Glucagon is required, the school nurse, or trained employee delegate, administers injection and positions student on his/her side. "911" will be called and parent/guardian notified. If awakens give ____grams of CHO.

______________________________________ ______________________ MD, DO, ANP, AP ____/____/____

Print Name: Health Care Provider **Signature** **Date**

Child's Name :________________________________ **D.O.B.: ____/____/____**

DIABETES MANAGEMENT PLAN IN SCHOOL AGREEMENT AND RELEASE

PARENT/GUARDIAN COMPLETES: I give permission to the school nurse, trained diabetes personnel, and other designated staff members of Cape May County Technical School to perform, to carry out, and/or to assist in the Diabetes Medical Management Plan for my child as outline by me and my child's health care team.

I consent to the release of information contained in this plan to school staff or emergency care personnel who may need to know this information. I consent to the release of information between my child's Diabetes Management Team (the treating Physician, Nurse Practitioner or Diabetic Educator) and the School Nurse.

I understand that my child should wear a medical identification bracelet or necklace at all times. As the school nurse is not available for after school activities, sporting events, or field trips, I will inform adult staff that may be in charge of an after school event or field trip, that my child has diabetes and ensure my child has his/her supplies available to manage his/her care. *

Note: The school nurse does not routinely go on school field trips, sporting events, and is not available for after school events. For this reason a school employee will be trained by the school nurse as a delegate to administer Glucagon to your child if he/she demonstrates symptoms of hypoglycemia and is unconscious, unable to swallow, or having a seizure believed to be related to hypoglycemia. (Additionally, "911" will be initiated in all such circumstances). It is the parent/guardian's responsibility to provide the Glucagon injection kit to the school. There is no delegate on the school bus to/from school therefore Glucagon will not be able to be given should an event occur on the school bus. The school bus driver will call "911" in the event your child exhibits signs of hypoglycemia and can not swallow, is unconscious or having a seizure. It is the guardian's responsibility to supply a source of quick acting glucose to the bus driver in the event your child should need it (we suggest two tubes of 15gm glutose gel).

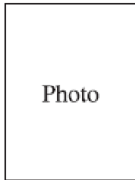
________________________________	________________________	_____/____/_____
PRINT NAME: Parent/Guardian	Signature	Date

If your child is not independent with management of his/her diabetes please contact the building Principal and school nurse for accommodations for field trips and school sponsored events.

STUDENT AGREEMENT:
I agree to make every attempt to follow the diabetic management plan outlined by my diabetes management team. I will notify a staff member if I feel symptoms of low or high blood sugar.
I AGREE TO DISPOSE OF ANY SHARPS OR MATERIAL THAT MAY CONTAIN BLOOD IN A SAFE MANNER. I WILL NOT DISPOSE OF SUCH LOOSE ITEMS IN THE SCHOOL TRASH.
(STUDENT MAY USE OWN SEALED CONTAINER FOR DISPOSAL LATER AT HOME OR USE THE SHARPS DISPOSAL IN THE SCHOOL NURSE'S OFFICE). I AGREE TO CLEAN UP THE TESTING AREA THAT MAY BECOME CONTAMINATED WITH DROPS OF BLOOD USING SCHOOL APPROVED ANTISEPTIC CLEANING WIPES.

Student's Signature ____ Date: ___/___/___

Quick Reference Emergency Plan
for a Student with Diabetes



Hypoglycemia
(Low Blood Sugar)

Student's Name

Grade/Teacher Date of Plan

Emergency Contact Information:

Mother/Guardian **Father/Guardian**

Home phone Work phone Cell Home phone Work phone Cell

School Nurse/Trained Diabetes Personnel **Contact Number(s)**

Never send a child with suspected low blood sugar anywhere alone.

Causes of Hypoglycemia
- Too much insulin
- Missed food
- Delayed food
- Too much or too intense exercise
- Unscheduled exercise

Onset
- Sudden

Symptoms

Mild
- Hunger
- Shakiness
- Weakness
- Paleness
- Anxiety
- Irritability
- Dizziness
- Sweating
- Drowsiness
- Personality change
- Inability to concentrate
- Other: ________

Circle student's usual symptoms.

Moderate
- Headache
- Behavior change
- Poor coordination
- Blurry vision
- Weakness
- Slurred Speech
- Confusion
- Other ________

Circle student's usual symptoms.

Severe
- Loss of consciousness
- Seizure
- Inability to swallow

Circle student's usual symptoms.

Actions Needed

Notify School Nurse or Trained Diabetes Personnel. If possible, check blood sugar, per Diabetes Medical Management Plan. When in doubt, always TREAT FOR HYPOGLYCEMIA.

Mild
- Student may/may not treat self.
- Provide quick-sugar source.
  3-4 glucose tablets
  or
  4 oz. juice
  or
  6 oz. regular soda
  or
  3 teaspoons of glucose gel
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than ______.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

Moderate
- Someone assists.
- Give student quick-sugar source per MILD guidelines.
- Wait 10 to 15 minutes.
- Recheck blood glucose.
- Repeat food if symptoms persist or blood glucose is less than ______.
- Follow with a snack of carbohydrate and protein (e.g., cheese and crackers).

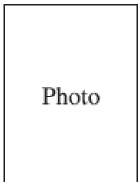
Severe
- Don't attempt to give anything by mouth.
- Position on side, if possible.
- Contact school nurse or trained diabetes personnel.
- Administer glucagon, as prescribed.
- Call 911.
- Contact parents/guardian.
- Stay with student.

The *Quick Reference Emergency Plan* can be found in NDEP's "Helping the Student with Diabetes Succeed: A Guide for School Personnel," which is available for free download at http://www.ndep.nih.gov/diabetes/pubs/youth_ndepschoolguide.pdf

Quick Reference Emergency Plan

for a Student with Diabetes

Hyperglycemia
(High Blood Sugar)



Student's Name

Grade/Teacher Date of Plan

Emergency Contact Information:

Mother/Guardian **Father/Guardian**

Home phone Work phone Cell Home phone Work phone Cell

School Nurse/Trained Diabetes Personnel

Contact Number(s)

Causes of Hyperglycemia

- Too much food
- Too little insulin
- Decreased activity
- Illness
- Infection
- Stress

Onset

- Over time—several hours or days

Symptoms

Mild

- Thirst
- Frequent urination
- Fatigue/sleepiness
- Increased hunger
- Blurred vision
- Weight loss
- Stomach pains
- Flushing of skin
- Lack of concentration
- Sweet, fruity breath
- Other: _______________

Circle student's usual symptoms.

Moderate

- Mild symptoms plus:
- Dry mouth
- Nausea
- Stomach cramps
- Vomiting
- Other:_______________

Circle student's usual symptoms.

Severe

- Mild and moderate symptoms plus:
- Labored breathing
- Very weak
- Confused
- Unconscious

Circle student's usual symptoms.

Actions Needed

- Allow free use of the bathroom.
- Encourage student to drink water or sugar-free drinks.
- Contact the school nurse or trained diabetes personnel to check urine or administer insulin, per student's Diabetes Medical Management Plan.
- If student is nauseous, vomiting, or lethargic, ____ call the parents/guardian or ____ call for medical assistance if parent cannot be reached.

The *Quick Reference Emergency Plan* can be found in NDEP's "Helping the Student with Diabetes Succeed: A Guide for School Personnel," which is available for free download at http://www.ndep.nih.gov/diabetes/pubs/youth_ndepschoolguide.pdf